DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445217	A. BUILDING _____ B. WING _____	11/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE CARE & REHABILITATION CENTER	1200 SPRUCE LANE ELIZABETHTON, TN 37643

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, review of facility policy, and interview the facility failed to ensure dignity was maintained for one resident (#87) of thirty-three sampled residents. The findings included: Resident #87 was admitted to the facility on October 19, 2009, with diagnoses including fracture of Femur and Forearm, Aphasia, Dysphagia, Senile Dementia, and Late Effects of Cerebral Vascular Event. Review of the care plan dated October 19, 2011 revealed the resident had impaired cognitive skills related to short term memory. Review of the listed approaches revealed, "Promote Dignity. Converse with resident and ensure privacy while providing care." Review of the Minimum Data Set (MDS) dated October 18, 2011, revealed the resident was dependent on the staff for all activities of daily living. Review of the MDS revealed the resident was aphasic (unable to speak.) Observation on November 15, 2011, at 2:13 p.m., revealed three certified nursing assisants (CNA's	F 241	**Pine Ridge Care and Rehab** **The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiency herein.** **The following plan constitutes the center's allegation of substantial compliance such that the alleged deficiencies cited have been corrected by the date(s) indicated.** **F241: The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.** 1. The Resident # 87 received a full IDT assessment and the care plan was reviewed, revised as indicated to ensure privacy and dignity were care planned for this resident. CNA's 1,2,3 were immediately inserviced to always ensure privacy is maintained at all times and especially when roommate is in the room. Curtains will be drawn and nursing admin staff will constantly monitor daily rounds to ensure there are no deviations from practice. All CNA's on that unit were	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241	Continued From page 1 #1, 2, 3) providing incontinence care to resident #87 in the resident's room. Observation revealed the resident was being supported to stand by a CNA on each side of the resident and one CNA provided incontinence care. Continued observation revealed the CNAs were providing care to the resident in the room between bed A and bed B. Continued observation revealed the alert roommate sitting in the chair watching the care being performed. Interview outside the resident room with CNA #1 on November 15, 2011, at 2:30 p.m., verified the curtain was not pulled, and the roommate did observe the personal care being performed. Review of the facility policy titled, Perineal Care dated 12-2010, revealed "...Provide privacy for the resident. Close the door, window blind and privacy curtain..." Interview at the 300 hall nurse's station with the Director of Nursing on November 16, 2011, at 9:22 a.m., confirmed the facility failed to ensure the dignity of resident #87 was maintained.	F 241	required to demonstrate peri-care for female residents and were deemed clinically competent with no deviations from safe and proper practice. 2. Respectfully we admit that all residents must receive the utmost privacy and dignity protection. All facility staff will be in-serviced by December 15, 2011 by DON/ADON to ensure all residents are provided dignity and respect with delivery of all care. **12/15/11** 3. The DON/ADON/Unit Mgr will monitor daily x 14 days starting December 1, 2011 then monthly x 3 months to ensure privacy and dignity is followed according to company policy and procedures. DON/ADON will also additionally provide ongoing peri-care inservice . **Ongoing**	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending	F 280	4. The QA Team will monitor privacy and dignity during daily rounds and report findings to Administrator and DON. The Administrator or DON will report findings to monthly QA/QI meeting for follow-up if indicated.	

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F 280	Continued From page 2 physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview the facility failed to evaluate the effectiveness of the care plan for one (#5) of thirty-three residents sampled. The findings included: Resident #5 was admitted to the facility on June 3, 2010, with diagnoses including Atrial Fibrillation, Chronic Airway Obstruction, Anxiety, Hypertension, Congestive Heart Failure, Failure to Thrive, and Hypoxemia. Review of the care plan dated June 4, 2011, revealed an identified problem of "...difficulty chewing due to missing lower denture plate." Review of care plan interventions dated June 4, 2011, included a dental consult. Continued review revealed the care plan was revised in September 2011, with a projected goal date for the dental consult extended to December 2011. Observation and interview with the resident on November 14, 2011, in the resident's room, at	F 280	**F280: The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.** 1. IDT met and care plan was reviewed and revised as indicated. The clinic was contacted and estimated the delivery of the denture will be ready for fitting on December 14, 2011. The SSD will follow through until the matter is resolved in the best interest in the resident. 2. IDT met and all residents identified as having actual needs from dental/vision/hearing or potential needs for dental/vision/hearing were assessed; the care plans were reviewed, revised as indicated. All individual corrective actions required will be carried out by the SSD in a timely manner, but no later than December 15, 2011. 3. At all quarterly assessments; all residents will have their dental/vision/hearing needs identified, addressed and needing interventions carried out and care planned accordingly. 4. QA Team will monitor for residents at risk and report findings to SSD and Administrator on a quarterly basis. The SSD or Administrator will report findings to monthly QA/QI meeting.	12/14/2011 12/15/11 Ongoing

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F 280	Continued From page 3 11:02 a.m., revealed the resident answered "yes" when asked about having any chewing or eating problems. Continued interview revealed "I don't know why it is taking so long (to replace the denture plate)." Observation on November 15, 2011, at 12:15 p.m., revealed the resident in the dining room eating independently. Observation revealed the meal was a mechanical soft diet. Observation revealed the resident had no lower teeth. Interview with the Minimum Data Set Nurse (MDS nurse #1) in the MDS office on November 17, 2011, at 9:41 a.m., revealed the care plan team discussed the missing denture plate and stated, "every body (the facility staff) knew dental had been consulted and was working on it." Continued interview revealed the care plan team did revise the care plan and extended the goal without developing new approaches or discuss the progress of the dental consultation. Continued interview revealed the care plan team failed to measure the effectiveness of the intervention of the dental consultation. Interview and medical record review with the Director of Social Services in the social services office on November 16, 2011, at 8:14 a.m., revealed the consultant dental company evaluated the resident in August 2011 and again in October when they made a impression of her lower gum. Interview with the Assistant Director of Nursing (ADON) in the conference room on November 17, 2011, at 9:53 a.m., confirmed the facility failed to re-evaluate the effectiveness of the dental	F 280		

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F 280	Continued From page 4 consultation.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to follow physician's orders for medication administration for one resident (#77) of thirty-three sampled residents. The findings included: Resident #77 was admitted to the facility on August 18, 2011, and readmitted September 27, 2011, with diagnoses including Senile Osteoporosis, Venous Stasis, and Left Leg Cellulitis. Medical record review of the Minimum Data Set dated October 25, 2011, revealed the resident had a score of 13 (out of a possible total of 15), on the Brief Interview For Mental Status. Review of the November 2011 Medication Administration Record revealed the resident was to receive a weekly Fosamax dose (drug used to treat Osteoporosis) on November 6, 2011. The dose was circled as not given. Continued review revealed documentation the dose was not available to be given. No documentation was found showing the pharmacy, physician, or any other staff was notified to obtain the dose.	F 281	**F281: The services provided or arranged by the facility must meet professional standards of quality.** 1. Resident #77's care plan and MDS has been assessed, reviewed and revised as indicated by the IDT. MARS have been corrected. DON/ADON are monitoring all the MARS in the facility on a 60 day basis to ensure this does not recur. Med count has been validated. Clarification order has been written and nursing staff has been in-serviced. This resident will receive all medications in a timely manner as ordered by the physician. Facility nursing staff will be in-serviced by December 15, 2011 medication administration with concentration on weekly dosages of Fosamax. :12/15/11 2. Additional corrective actions required the ADON to identify a few other residents on same medication. their MDS and care plans have been assessed, reviewed and revised as indicated. The MARS have been checked and noted such to ensure the practices do no recur. DON/ ADON/RN Unit Manager are monitoring all the MARS in the facility on a 60 day basis daily. 3. DON/ADON will conduct audits of all MARS daily X 60 days then ongoing monthly to ensure professional standards of quality is given. Medical records will also assess for any deficit indications in thin records for the remainder of the year. **Ongoing**	

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F 281	Continued From page 5 Interview with the Director of Nursing (DON) on November 17, 2011, at 9:30 a.m., at the 100/200 Hall nurse's station confirmed the physician order for the weekly Fosamax dose was not followed.	F 281	4. QA Team will monitor for and medication discrepancies and report findings to DON/ ADON. DON or ADON will report findings to monthly QA/QI meeting.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to implement the care plan for one (#31) resident of thirty-three resident's reviewed. The findings included: Resident #31 was admitted to the facility on May 14, 2010, with diagnoses including Gastrointestinal Bleed, Urinary Tract Infection, Congestive Heart Failure, Anemia, Encephalopathy, and Psychosis. Medical record review of the Minimum Data Set dated October 17, 2011, revealed the resident had impaired short and long term memory, was non-ambulatory, and required maximum assistance of two with transfers. Medical record review of the resident's current care plan dated September 19, 2011, and last revised on November 7, 2011, and the current CNA (Certified Nurse Assistant) ADL (Activities of	F 282	**F282: The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.** 1. IDT met on November 17, 2011 and resident #31's MDS and care plan was reviewed and revised as indicated. Facility staff will be in-serviced by December 15, 2011 on following care plans and MDS's to identify the proper devices to be utilized. Facility staff will also be in-serviced on the proper utilization of each device. 12/15/11 2. DON/ADON identified other residents at risk for same practice and their MDS and care plans were assessed, reviewed and revised as indicated for the applicable lifts to be utilized. All facility staff will be in-serviced by December 15, 2011 on the proper utilization of all lifts within the facility and to only use the indicated lift on residents specific needs as ordered. 12/15/11 3. IDT met and all care plans were reviewed and revised as indicated to ensure qualified persons were in accordance with each resident's written plan of care.	

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F 282	Continued From page 6 Daily Living) sheets revealed the resident was transferred with assist of two persons and did not include the use of a mechanical lift. Observation on November 17, 2011, at 11:00 a.m., of CNA #4 and CNA #5 in the resident's room, revealed the CNA's used a sit to stand mechanical lift to assist the resident to stand for incontinence care. Observation revealed the CNA's placed the lift belt around the resident's chest just below the breasts. The belt was fastened by CNA #4 and was not snug. Continued observation revealed the CNA's placed the resident's hands on the lift bar, and initiated the lift, raising the resident to a semi-standing position. Continued observation revealed as the lift was rising the lift belt slid up to the resident's shoulders. Continued observation revealed the CNA's pulled the resident's pants down and removed the soiled brief. Continued observation revealed the resident slowly slid out of the lift belt, and fell approximately 12 inches onto the wheelchair seat below the resident. Continued observation revealed CNA #4 reapplied the lift belt below the breasts without ensuring a snug fit, and again placed the resident's hands on the lift bar. Continued observation revealed CNA #4 started lifting the resident to a semi-standing position and the lift belt again was sliding up to the resident's shoulders. The resident was yelling "...you're hurting my arms stop that..." The CNAs did not lower the resident, but continued to provide incontinence care. The CNAs applied the clean brief and pulled the resident's pants up. Continued observation revealed with the resident's arms/shoulders in the lift belt as the CNAs lowered the resident to the wheelchair. Interview with CNA #4 and CNA #5 at that time	F 282	4. All residents will be reviewed on their quarterly MDS Assessment for the continued need and assurance of proper utilization of any indicated lifts and care planned accordingly. This practice has been monitored since November 17, 2011 by DON/ADON/NHA and will continue through the end of the year and then will each quarterly assessment. **Ongoing**	

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F 282	Continued From page 7 confirmed the resident had not been safely transferred. Interview with CNA #4 and CNA #5 on November 17, 2011, at 2:55 p.m., on the 200 hallway, revealed the appropriate way to transfer a resident is on the care plan. Continued interview revealed the resident "doesn't have an order for the lift, and the resident doesn't stand well for transfers using a gait belt." Continued interview revealed the CNAs used the lift last week, and the "resident did okay with standing, so we decided to use it (the lift) to transfer the resident today." Continued interview also revealed the resident's ability to stand and transfer varies with how the resident feels and mood. Continued interview confirmed the resident's care plan was not implemented correctly.	F 282		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, review of facility policy, and interview, the facility failed to provide incontinence care in a sanitary	F 315	**F315: Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.** 1. Resident #31's care plan was assessed, reviewed and revised as indicated. She was care planned for proper peri-care and all staff were in-serviced for peri-care and the facility will in-service for peri-care x 8 weeks	12/15/11

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F 315	Continued From page 8 manner for one (#31) of two residents observed for incontinence care of thirty-three residents reviewed. The findings included: Resident #31 was admitted to the facility on May 14, 2010, with diagnoses including Gastrointestinal Bleed, Urinary Tract Infection, Congestive Heart Failure, Anemia, Encephalopathy, and Psychosis. Observation on November 17, 2011, at 11:00 a.m., in the resident's room, revealed CNA #4 and CNA #5 (Certified Nurse Assistant) assisted the resident with a sit to stand lift, to a semi standing position, pulled the resident's pants down, and removed the urine soiled brief. Continued observation revealed CNA #4 used a washcloth to wash the resident's pubic/labia area without turning the washcloth, and used a back and forth motion five times. Continued observation revealed CNA #4 dropped a washcloth on the floor, picked it up, and dried the resident's peri area using a back and forth motion three times. Review of the facility's Perineal Care Female Procedure revealed "...wipe resident from front of perineum to back of perineum (anal area)...pat skin dry with towel..." Interview on November 17, 2011, at 5:30 p.m., in the Admissions office with the Admissions Registered Nurse and the Corporate Registered Nurse both confirmed the incontinence care was not completed in a sanitary manner.	F 315	and monitor on daily rounds for the next 3 months. The Unit Mgr assessed resident post state observation for improper practices and did render proper peri-care to ensure the resident was dry and clean. 2. DON/ADON identified other incontinent residents and their care plans have been reviewed, assessed and revised as indicated to ensure proper peri-care is rendered and so noted in care plans. A series of major peri-care in-services were conducted on November 17, 2011 through December 15, 2011. 12/15/11 3. DON/ADON/Unit Mgrs will conduct daily audits X 14 days then monthly x 3 months to ensure that proper peri-care practices have been achieved, delivered and ongoing. 4. The QA team will monitor peri-care during daily rounds and report findings to DON/ADON. The DON or ADON will report findings to monthly QA/QI meetings.	
F 323	483.25(h) FREE OF ACCIDENT	F 323	**F323: The facility must ensure that the resident Environment remains as free of accident hazards As is possible; and each resident receives adequate**	

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F 323 SS=D	Continued From page 9 HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to safely transfer one (#31) resident of seven reviewed for transfers of thirty-three residents reviewed. The findings included: Resident #31 was admitted to the facility on May 14, 2010, with diagnoses including Gastrointestinal Bleed, Urinary Tract Infection, Congestive Heart Failure, Anemia, Encephalopathy, and Psychosis. Medical record review of the Minimum Data Set dated October 17, 2011, revealed the resident had impaired short and long term memory, was non-ambulatory, and required maximum assistance of two persons with transfers. Medical record review of the resident's current care plan dated September 19, 2011, and last revised on November 7, 2011, and the CNA (Certified Nurse Assistant) ADL (Activities of Daily Living) sheets revealed the resident was transferred with assist of two persons and did not	F 323	**Supervision and assistance devices to prevent Accidents.** 1. Resident #31 Care Plan/MDS has been assessed, reviewed, received as indicated. The CNA care plan is also correctly noted. The resident will be transferred as medically indicated with a two person assist not a mechanical lift unless otherwise deemed necessary. 2. Other residents identified at risk for this practice have been assessed by the DON and now their care plans, MDS and aide care plans have been assessed, revised as indicated to ensure use of human assisted transfers and lifts occur or mechanical lifts and transfers occur as indicated. All staff have been in-serviced on how the residents are coded for lifts and transfers. All staff have been in-serviced on safe and proper use of all devices in the facility. 3. The DON, ADON and Department heads will all monitor this practice in daily rounds x 8 weeks. 4. QA Team will monitor this practice In daily rounds x 8 weeks.	11/17/11 12/15/11 **Ongoing**

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445217	A. BUILDING _____ B. WING _____	11/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE CARE & REHABILITATION CENTER	1200 SPRUCE LANE ELIZABETHTON, TN 37643

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F 323	Continued From page 10 include using a mechanical lift. Observation on November 17, 2011, at 11:00 a.m., of CNA #4 and CNA #5 in the resident's room revealed the CNAs used a sit to stand mechanical lift to assist the resident to stand for incontinence care. Observation revealed the CNA's placed the lift belt around the resident's chest just below the breasts. The belt was fastened by CNA #4 and was not snug. Continued observation revealed the CNA's placed the resident's hands on the lift bar, and initiated the lift, raising the resident to a semi-standing position. Continued observation revealed as the lift was rising, the lift belt slid up to the resident's shoulders. Continued observation revealed the CNAs pulled the resident's pants down and removed the soiled brief. Continued observation revealed the resident slowly slid out of the lift belt and fell approximately twelve inches into the wheelchair seat below the resident. Continued observation revealed CNA #4 reapplied the lift belt below the breasts without ensuring a snug fit, and again placed the resident's hands on the lift bar. Continued observation revealed CNA #4 started lifting the resident to a semi-standing position and the lift belt again was sliding up to the resident's shoulders. Continued observation revealed the resident was yelling "...you're hurting my arms stop that..." The CNAs did not lower the resident, but continued to provide incontinence care. The CNAs applied the clean brief and pulled the resident's pants up. Continued observation revealed with the resident's arms/shoulders in the lift belt, the CNAs lowered the resident to the wheelchair. Interview with CNA #4 and CNA #5 at that time confirmed the resident had not been safely transferred.	F 323		

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F 323	Continued From page 11 Interview with the Assistant Director Of Nursing on November 17, 2011, at 2:10 p.m., at the 100/200 nurse's desk revealed if the CNAs notice a resident is having difficulty with transferring they are to tell their charge nurse. Continued interview revealed the concern will be brought to the weekly care meeting and discussed with therapy. Continued interview revealed therapy evaluates the resident if needed. Continued interview confirmed the resident had not been transferred safely. Interview with the Physical Therapist (PT) on November 17, 2011, at 2:20 p.m., in the therapy office revealed the resident is not appropriate for using a sit to stand mechanical lift especially due to fears while being transferred. Continued interview revealed the correct way to place the lift belt for the sit to stand lift is to place the belt around the pelvis, if placed around the chest it is easy to slide up on to the shoulder and arms. Interview with CNA #4 and CNA #5 on November 17, 2011, at 2:55 p.m., on the 200 hallway, revealed the appropriate way to transfer a resident is on the care plan. Continued interview revealed the resident "doesn't have an order for the lift, and the resident doesn't stand well for transfers using a gait belt." Continued interview revealed the CNAs used the lift last week, and the "resident did okay with standing; so we decided to use it (the lift) to transfer the resident today." Continued interview also revealed the resident's ability to stand and transfer varies with how the resident feels and mood. Continued interview confirmed the CNAs had not notified the charge nurse of the resident's difficulty with transfers.	F 323		

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F 364 SS=F	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the nutritive value was maintained for the mechanically altered diet for fourteen of fourteen residents on puree diet. The findings included: Observation in the dietary department on November 15, 2011, at 9:45 a.m., revealed cook #1 was preparing to mechanically alter the pork riblets into a puree. Continued observation revealed cook #1 opened the recipe book and referred to the recipe of breaded pork cutlet. Continued observation revealed cook #1 added 7 riblets (3 ounces) and 4 pieces of sliced white bread into a food processor. Continued observation revealed the cook then added tap water into a clear water pitcher. Observation revealed the cook then poured the unmeasured water into the processor and continued to process the meat and bread. After a few minutes the cook turned off the processor and with a spoon assessed the consistency of the processed meat and bread. When asked what the consistency is prescribed	F 364	**F364: Each Resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable attractive, and at the proper temperature.** 1. Facility Dietary Staff have conducted a Major re-implementation of the Facility Dietary Services Policy and Procedure. The RD will in-service the Dietary Manager by December 15th, 2011 on Following all policies related to the Process and delivery of Puree meals. All Dietary staff have been given handouts and copies of the requirements for the Puree process. All the Dietary Staff have been in-serviced. A sister Company Dietary Manager has conducted an 8 hour 1:1 with Dietary manager. 2. The Administrative team and Regional SCC/RN and RD will meet in the facility For an 8 hour review of the Dietary Department before December 15, 2011 To ensure that there are no other residents Affected by this practice. This meeting will include a careful meal preparation and delivery review of each resident that has orders for Puree. The RD of record will review all the Puree recipes and make changes as indicate by December 15, 2011. RD will assess and review that all meals are being	12/15/11

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F 364	Continued From page 13 the cook responded "I dont know...I just go by how it looks..it cannot be runny." When asked if a recipe was followed the cook responded "No, that one was for breaded pork and what we have today is not breaded." Continued observation revealed the cook repeated the process with 7 riblets and 4 pieces of bread in the processor; and again added the unmeasured water. Continued observation revealed the cook repeated the process to puree a total of 17 riblets and 17 pieces of bread. Interview with the Dietary Manager in the dietary department on November 15, 2011, at 9:59 a.m., revealed the recipe to puree the riblet "Was not available because we just changed menus for the winter season." Continued interview revealed the facility failed to ensure the nutritive value was maintained for the mechanically altered diet.	F 364	prepared, processed and delivered to ensure that all required nutritive values, appearance, Temps and the palatable factors are positive and acceptable. 3. The RD will review the Puree and Meal Delivery process on a monthly basis. The NHA and DON will assess the Puree Dietary Process on a weekly basis for 12 weeks once a week and then once a week for six months. 4. The QA team will implement the Utilization of a Dietary Evaluation Checklist and this Will be reviewed by the QA team quarterly. The NHA and DON will continue to monthly Request puree trays to test and taste to ensure that deficit practices have not recurred.	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy,	F 371	**F371: The facility must-** **(1) Procure food from sources Approved or considered satisfactory by Federal, State or local authorities; and** **(2) Store, prepare, distribute and serve food under sanitary conditions.** **11/15/2011** 1. Dietary staff have been in-serviced on the Facility Policies and Procedures on the Food Procurement, storage and preparation. The focus of this in-service was on the issue of avoiding bare hand contact with the utensil	

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F 371	Continued From page 14 and interview, the facility failed to handle eating utensils used by all residents in a sanitary manner. The findings included: Observation on November 15, 2011, at 11:15 a.m., in the facility kitchen, revealed dietary staff with the bare hands picked up a fork, knife, and spoon, placed the utensils in a napkin and rolled it, repeating the task multiple times, and placed the utensils in a container ready to be placed on the resident trays for lunch. Review of facility policy, Handling of Eating Utensils, revealed "After the eating utensils and dishes have been sanitized, the fingers should not touch any surface that would come in contact with the food. This includes...forks, spoons, bowls, and knife blades..." Interview with the Dietary Manager on November 15, 2011, at 3:32 p.m., confirmed the facility failed to handle the utensils in a sanitary manner.	F 371	ends that come in contact with food. The Facility Dietary Manager has place proper gloves in the areas needed to ensure that this practice does not recur. This in-service was completed on November 15, 2011 and will Be conducted monthly x three months. 2. All Department Heads and Administative Team will be in-serviced and educated as To safe acceptable practices are being implemented on a daily basis by December 15, 2011 so that all eyes in the facility can ensure that this practice does not affect other residents. 3. Disposable gloves are now in accessible locations to all staff that handle the utensils. The Dietary Manager will monitor this practice daily. 4. The QA team will review the Dietary Checklist In the QA process quarterly to ensure that all measures have remained successful. The DON/ADON and NHA will monitor this in an ongoing manner while on their daily rounds.	12/15/11
F 411 SS=D	483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS The facility must assist residents in obtaining routine and 24-hour emergency dental care. A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation	F 411	**F411: The facility must assist residents in obtaining Routine and 24-hour emergency dental care.** 1. On November 14, 2011 the SSD followed up on the Interventions that were pending related to the Obtainment of this resident's dentures. The providing dental lab has verbalized an anticipated	

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F 411	Continued From page 15 to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure the consulted dental service promptly provided service for one (#5) resident of thirty-three sampled residents. The findings included: Resident #5 was admitted to the facility on June 3, 2010, with diagnoses including Atrial Fibrillation, Chronic Airway Obstruction, Anxiety, Hypertension, Congestive Heart Failure, Failure to Thrive, and Hypoxemia. Observation and interview with the resident on November 14, 2011, in the resident's room, at 11:02 a.m., revealed the resident answered "yes" when asked about having any chewing or eating problems. Continued interview revealed "I don't know why it is taking so long (to replace the dental plate)." Review of the care plan dated June 4, 2011, revealed an identified problem of chewing due to missing lower denture plate. Review of the interventions included a dental consult. Interview and medical record review with the Director of Social Services in the social services office on November 16, 2011, at 8:14 a.m., revealed the consultant dental company	F 411	delivery date of the denture of 12/14/11. An IDT meeting was conducted on November 16, 2011 And an assessment, review and revisions of the Plan of care were made as indicated. The SSD and NHA will ensure that the delivery of the denture is made as timely as possible and this will be followed up on weekly by the SSD until the delivery is made. The SSD, DM and DON will follow up weekly x 12 weeks to ensure that the denture is acceptable, proper fit, and conducive to aiding the resident in nutritional consumption. **Ongoing** 2. A special team meeting will be conducted regarding routine dental needs by December 15, 2011, by the entire IDT and a facility wide assessment will be made on all residents in the facility to identify any and all other residents that may also have dental needs that are unmet. **12/15/11** 3. After the December 15, facility wide assessment, all residents will continue to be assessed on a quarterly basis for dental needs in conjunction with their routine MDS assessments and or any other MDS assessment. Facility staff will be in-serviced by December 15, 2011 to educate all staff to report any dental needs, concerns, or issues regarding Dental in the morning meeting. A 1:1 in-service will be provided to the SSD and IDT by December 15, 2011 by the Regional SCC related to ensuring that all dental needs are identified and met in an ongoing manner. **12/15/11** 4. The QA team will monitor the effectiveness of all the corrective measures in the quarterly QA process.	

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F 411	Continued From page 16 evaluated the resident in August 2011 and again in October 2011 when they made an impression of the lower gum. Continued interview revealed the facility does not have a system to follow-up with the consulted dental service to assure the service was provided in a timely manner. Interview with the Assistant Director of Nursing in the conference room on November 17, 2011, at 9:53 a.m., verified the dental service had been consulted in June 2011 and the resident remained without the replaced dental plate five months later. Continued interview revealed the facility failed to assure the consulted dental service provided a service in a timely manner.	F 411		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must	F 441	**F441: The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.** 1. The RN observed as having the deficit practice of the bare hands touching the food was in-serviced c immediately following the practice. The DON/ADON will monitor this RN and her practices related to this. **Ongoing** 2. All facility staff will be in-serviced on the proper handling of food in the meal process and to avoid the use of bare hands touching food during the meal process byDecember 15, 2011. The DON/NHA/DM /RN Unit Manager will monitor the meal process daily	

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F 441	Continued From page 17 isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide food in a sanitary manner for one (#31) of thirty-three residents reviewed. The findings included: Observation on November 16, 2011, at 5:00 p.m., in the dining room, revealed resident #31 sitting at the table not eating a sandwich. Continued observation revealed Registered Nurse (RN) #3 with the bare hands picked up 1/2 sandwich and held it to the resident's mouth to take a bite, placed the 1/2 sandwich on the plate, stirred the resident's soup, and with the bare hands picked up the other 1/2 sandwich and placed it in the resident's hand. Interview with RN #3 on November 16, 2011, at 5:05 p.m., in the hallway outside of the dining	F 441	for 12 weeks and then weekly for6 months. This will be in the format of a check list. The IDT will all monitor the dining room in an ongoing manner to ensure that this deficit practice does not recur. **12/15/11** 3. A facility wide in-service will be conducted by December 15, 2011 related to the proper P/P on avoiding the practice and eliminating the risk of bare hands touching the food in the delivery , feeding or meal set up process. Gloves will remain available in the dietary dept and areas where meals are served , set up or fed. The Dept head assigned to the dining rooms will monitor this in an ongoing manner. The unit managers on the halls will monitor this in an ongoing manner for those residents that dine in the rooms. **12/15/11** 4. The DON and ADON and DM will continue to monitor: that the gloves are available, that the staff are utilizing them and that no bare hand to food contact occurring in the meal process. The QA team will also review this practice in the Dietary QA quarterly and also in the Infection Control Process Review Quarterly. Any identification of exposure or risk being actual or potentially being an infectious practices will continue to be monitored in an ongoing basis by the QA Team. **Ongoing**	

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F 441	Continued From page 18 room, confirmed the facility failed to handle the food in a sanitary manner.	F 441		